



## UNITED STATES PARK POLICE

Police and Fire Clinic  
920 Varnum St. NE  
Washington, DC 20017  
202-269-7435

### ALLERGY INFORMATION

RE: \_\_\_\_\_  
(Print/Type Name of Patient/Applicant)

**\*\* APPLICANT – SIGN UNDER THE APPROPRIATE SECTION (either 1, 2 or 3). IF YOU ARE UNDER MEDICAL CARE FOR ALLERGIES YOUR HEALTH CARE PROVIDER MUST COMPLETE PAGES 2 and 3.**

- 1 I certify that I do not have any allergies.

\_\_\_\_\_  
Signature and date

2. I certify that I have seasonal allergies but that I am not under medical care. Symptoms are treated with over the counter medications only.

\_\_\_\_\_  
Signature and date

3. I am under medical care for allergies. My medical provider's evaluation is attached.

\_\_\_\_\_  
Signature and date

## ALLERGY INFORMATION

RE:

\_\_\_\_\_  
(Print/Type Name of Patient/Applicant)

This memorandum, reference the above named applicant to the UNITED STATES PARK POLICE, a uniformed branch of the protective services. is a request for definitive information regarding any allergic disorder. The applicant must perform his/her duties as a law enforcement officer in all forms of weather, and on rotating shifts. He/she is exposed to pollen, and all other forms of allergic substances in the area, in all seasons of the year. For these reasons a definitive opinion is necessary for us to complete his/her medical clearance for the department. We are in need of answers to the following questions:

1. The above named applicant has (please c\YW\ all that apply):  
**Hay Fever; Asthma; Urticaria; Eczema; Hypersensitivity to insect stings.**
2. The positive allergic disorder(s) noted above is/are (please 'W\YW\ 'h\Y'cbY'h\Uh'Udd'JYg):  
**Seasonal (which season? \_\_\_\_\_). Mild Moderate Severe.**
3. Does he/she have symptoms (please check box):  
**Daily Weekly Monthly Seasonal**

Please identify symptoms:

\_\_\_\_\_  
\_\_\_\_\_

4. Has he/she had skin tests for potential allergies? **Yes No**  
Which ones?

\_\_\_\_\_  
Please list the results:

\_\_\_\_\_  
\_\_\_\_\_

5. Is there a family history for allergic disorders? **Yes No**
6. Has he/she received desensitization treatment? **Yes No**  
\_\_\_\_\_
7. Is he/she currently receiving desensitization treatment? **Yes No**
8. Does he/she take prescription antihistamines? **Yes No**  
Non-prescription antihistamines? **Yes No**  
How often ? \_\_\_\_\_
9. What was the date of the last episode of allergic attack? \_\_\_\_\_

10. Does patient take steroids? **Yes** **No**  
Which ones and how often?

\_\_\_\_\_.

Prescribed nasal sprays? **Yes** **No**  
Which ones and how often?

\_\_\_\_\_.

Non-prescribed nasal sprays? **Yes** **No**  
Which ones and how often?

\_\_\_\_\_.

11. Is the patient taking oral bronchodilators or other medication for asthma?  
**Yes** **No**

Frequency? \_\_\_\_\_.

COMMENTS:

\_\_\_\_\_  
Treating Physicians Name – PRINT

Address: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physicians Signature and date

\_\_\_\_\_  
Telephone Number